Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-10-4287-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: ACE AMERICAN INSURANCE CO Box #: 15	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Pre authorization #4194720/Per MAR"

Amount in Dispute: $15,200.00

PART III: RESPONDENT'S POSITION SUMMARY

The respondent did not respond to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
7/6/09	97799-CP	N/A	$800.00	$0.00
7/7/09	97799-CP	N/A	$800.00	$0.00
7/8/09	97799-CP	N/A	$800.00	$0.00
7/9/09	97799-CP	N/A	$800.00	$0.00
7/10/09	97799-CP	N/A	$800.00	$0.00
7/14/09	97799-CP	N/A	$800.00	$0.00
7/17/09	97799-CP	N/A	$800.00	$0.00
7/20/09	97799-CP	N/A	$800.00	$0.00
7/21/09	97799-CP	N/A	$800.00	$0.00
7/22/09	97799-CP	N/A	$800.00	$0.00
8/10/09	97799-CP	N/A	$800.00	$0.00
8/11/09	97799-CP	N/A	$800.00	$0.00
8/13/09	97799-CP	N/A	$800.00	$0.00
8/14/09	97799-CP	N/A	$800.00	$0.00
8/17/09	97799-CP	N/A	$800.00	$0.00
8/18/09	97799-CP	N/A	$800.00	$0.00
8/19/09	97799-CP	N/A	$800.00	$0.00
8/20/09	97799-CP	N/A	$800.00	$0.00
8/25/09	97799-CP	N/A	$800.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits:

   - No explanation of benefits submitted

Issues

1. Did the requestor submit the medical fee dispute in accordance with 28 Tex. Admin. Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted this medical fee dispute for the above listed dates and services. The requestor did not submit any EOB's in this dispute. Pursuant to rule §133.307(c)(2)(B) Provider requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute **or**, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The requestor did not submit any evidence of carrier receipt for the request of EOB's for the services in dispute. In absence of the EOB's and in absence of a response from the respondent, the Division is unable to determine if the insurance carrier actually received the disputed bills or what the denial reason(s) may be. Therefore, the Division concludes that the requestor did not submit this medical fee dispute in accordance with rule §133.307 and reimbursement to the requestor for the above listed dates of service is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	6/29/11 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.